

## SECTION 2

### PSYCHOLOGY SERVICES

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## 1 PSYCHOLOGY SERVICES

### 1 - 1 General Policy

Outpatient psychology services provided by licensed psychologists are limited to children who are eligible for the CHEC program through Medicaid **and** who are **not** enrolled in a Prepaid Mental Health Plan (PMHP). **See Chapter 1 - 3, Definitions, for the definitions of CHEC and PMHP.** Children enrolled in a PMHP must receive psychologist services from the mental health center printed on the Medicaid Identification Card.

There are THREE exceptions to the rule that these children must receive all psychologist services from the mental health center identified on the Medicaid Identification Card :

#### **Exception 1: Children in Foster Care**

Children in foster care or under state custody are enrolled in a Prepaid Mental Health Plan **for inpatient mental health services only**. These children may receive *outpatient* psychologist services from licensed psychologists in private practice.

#### **Exception 2: Children enrolled in HMOs**

Health Plans are responsible for diagnostic work-ups for developmental disorders and organic disorders. Therefore, psychological evaluation and testing to assess these disorders are covered by the child's Health Plan. If the child is not enrolled in a Health Plan, these services would be covered under this program. (See Chapter 3, Prior Authorization, for services provided before October 1, 2003.)

#### **Exception 3: Children in subsidized adoptions who have been formally exempted from the PMHP by the Medicaid agency.**

Such exemptions are on a case-by-case basis only and must be requested by the child's adoptive parent.

**Location of Services:** Psychology services may be provided in the psychologist's office, an outpatient hospital setting, or other appropriate setting, to Medicaid clients who meet the specific criteria as outlined in this manual.

**NOTE:** Psychology services provided to inpatients of a hospital are NOT eligible for reimbursement under the Medicaid Psychology Program. Such services are covered either (1) by a Prepaid Mental Health Plan for patients who are enrolled in a PMHP or (2) if the patient is not enrolled in a PMHP, in the DRG payment to the hospital.

### 1 - 2 Qualified Psychologists

Psychology services must be provided by:

1. a licensed psychologist practicing within the scope of his or her licensure in accordance with Title 58, Utah Code Annotated, 1953, as amended; or
2. a certified psychology resident working under the supervision of a licensed psychologist.

On the Request for Prior Authorization Form, please state the psychology resident's name, the name of the university and the program in which he or she is enrolled, and a brief description of the supervision provided.

(See Title 58 of the Utah Code Annotated, 1953, as amended, or the particular profession's practice act rule for supervision requirements.)

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### 1 - 3 Definitions

**CHEC:** Child Health Evaluation and Care is Utah's version of the federally mandated Early Periodic screening Diagnosis and Treatment (EPSDT) program. All Medicaid eligible clients from *birth through age twenty* are enrolled in the CHEC program. The only exception to this policy is that Medicaid clients age 19 and older enrolled in the Non-Traditional Medicaid Plan are **not** eligible for the CHEC program. The Medicaid Identification Cards for individuals enrolled in the Non-Traditional Medicaid Plan are blue in color and specify that the individual is enrolled in this plan.

**Prepaid Mental Health Plan (PMHP):** A managed care plan offering coverage for mental health care services. The services covered are specified in the PMHP contract with Medicaid. Medicaid clients in certain geographic areas of the state receive inpatient and outpatient mental health services through selected contractors (community mental health centers) paid on a capitation basis.

**Health Plan:** A plan that contracts with the Medicaid agency, the Division of Health Care Financing, to provide medical services to individuals covered by Medicaid.

### 1 - 4 Treatment Plan

- A. If it is determined the individual needs psychological services, the psychologist must develop an individualized treatment plan.
- B. The treatment plan is a written, individualized plan which contains measurable treatment goals related to problems identified in the psychiatric diagnostic interview examination. The treatment plan must be designed to improve and/or stabilize the client's condition.
- C. The treatment plan must include the following:
  1. measurable treatment goals developed in conjunction with the client;
  2. the treatment regimen—the specific treatment methods that will be used to meet the measurable treatment goals;
  3. a projected schedule for service delivery, including the expected frequency and duration of each treatment method; and
  4. the credentials of individuals who will furnish the services.
- D. Long-term goals or discharge plan.

### 1 - 5 Documentation

- A. The provider must develop and maintain sufficient written documentation for each medical or remedial therapy, service, or session for which billing is made.
- B. See Chapter 2, Scope of Services, for documentation requirements specific to each service.
- C. The clinical record must be kept on file, and made available for State or Federal review, upon request.

## 2 SCOPE OF SERVICES

Psychological services include the following:

- Psychiatric Diagnostic Interview Examination (Evaluation);
- Psychological Testing;
- Individual Psychotherapy (Individual Therapy);
- Family Psychotherapy (Collateral Therapy); and
- Group Psychotherapy (Group Mental Health Therapy)

Prior authorization is not required for services provided on or after October 1, 2003. See Chapter 3 for more information on this change.

### 2 - 1 Psychiatric Diagnostic Interview Examination (Initial Evaluation)

**Psychiatric diagnostic interview examination** means a face-to-face evaluation identifying the existence, nature or extent of psychological impairment or deterioration of functioning in a client for the purpose of determining the client's need for medically necessary services and establishing written objectives for the provision of such services, as appropriate.

**Record:** Psychiatric Diagnostic Interview Examination:

1. date and actual time of the service;
2. duration of the service;
3. setting in which the service was rendered;
4. specific service rendered (i.e., psychiatric diagnostic interview examination);
5. summary of psychiatric diagnostic interview examination findings that includes:
  - a. history;
  - b. diagnoses; and
  - c. summary of recommended mental health treatment services, and other recommended services as appropriate; and
6. signature and title of individual who rendered the service.

**Unit:** **90801 - Psychiatric Diagnostic Interview Examination - per 15 minutes;**

**90802 - Psychiatric Diagnostic Interview Examination** - Interactive psychiatric diagnostic interview examination using play equipment, physical devices, language interpreter, or other mechanisms of communication - **per 15 minutes**

When billing or reporting these procedures, round to the nearest full unit. For example, 22 minutes of service equals 1 unit; 23 minutes of service equals 2 units.

- Limits:**
1. The initial evaluation session is limited to individuals eligible for EPSDT (CHEC) services.
  2. The initial evaluation for children with a developmental disorder or organic disorder who are enrolled in a Health Plan is covered by the Health Plan.

The following services are not covered services under Medicaid and may not be billed to Medicaid:

3. Evaluations which are not medically necessary or are for the purpose of court determinations only, including but not limited to such issues as custody or visitation, are **not** a covered service.
4. Services where the therapist or others during the session use coercive techniques (e.g., coercive physical restraints, including interference with body functions such as vision, breathing and movement, or noxious stimulation) to evoke an emotional response in the child such as rage or to cause the child to undergo a rebirth experience. Coercive techniques are sometimes also referred to as holding therapy, rage therapy, rage reduction therapy or rebirthing therapy.
5. Services wherein the therapist instructs and directs parents or others in the use of coercive techniques that are to be used with the child in the home or other setting outside the therapy session.

## 2 - 2 Psychological Testing

Psychological testing means administering, evaluating, and submitting a written report of the results of psychometric, diagnostic, projective or standardized IQ test by a licensed psychologist.

- Record:**
1. date(s) and actual time(s) of testing;
  2. duration of the testing;
  3. setting in which the testing was rendered;
  4. specific service rendered;
  5. signature and title of individual who rendered the service; and
  6. written test reports which include:
    - a. brief history
    - b. tests administered;
    - c. test scores;
    - d. evaluation of test results;
    - e. current functioning of the examinee;
    - f. diagnoses;
    - g. prognosis; and
    - h. specific treatment recommendations for mental health services, and other recommended services as appropriate.

**Unit:** **96100 - Psychological Testing** - includes psychodiagnostic assessment of personality, psychopathology, emotionality, intellectual abilities, e.g., WAIS-R, Rorschach, MMPI, with interpretation and report - **per hour**

**96105 - Assessment of Aphasia** - includes assessment of expressive and receptive speech and language function, language comprehension, speech production ability, reading spelling, writing, e.g., Boston Diagnostic Aphasia Examination, with interpretation and report - **per hour**

**96110 - Developmental Testing: limited** - e.g., Developmental Screening Test II, Early Language Milestone Screen, with interpretation and report - **per hour**

**96111 - Developmental Testing: extended** - includes assessment of motor, language, social, adaptive and/or cognitive functioning by standardized developmental instruments, e.g., Bayley Scales of Infant Development, with interpretation and report - **per hour**

**96115 - Neurobehavioral Status Exam** - Clinical assessment of thinking, reasoning and judgment, e.g., acquired knowledge, attention, memory, visual spatial abilities, language functions, planning, with interpretation and report - **per hour**

**96117 - Neuropsychological Testing Battery** - e.g., Halstead-Reitan, Luria, WAIS-R, with interpretation and report - **per hour**

When billing or reporting these procedure codes, round to the nearest full unit. For example, 1 hour and 29 minutes of service equals 1 unit and 1 hour and 30 minutes of service equals 2 units.

**Limits:**

1. Psychological testing is limited to individuals eligible for EPSDT (CHEC) services.
2. Individuals who are residents of an ICF/MR are not eligible for this service. The cost of this service is included in the rate paid to the ICF/MR.
3. Psychological testing, including neuropsychological testing, for children with a developmental disorder or organic disorder who are enrolled in a Health Plan is covered by the Health Plan.

The following services are not covered services under Medicaid and may not be billed to Medicaid:

4. Services where the therapist or others during the session use coercive techniques (e.g., coercive physical restraints, including interference with body functions such as vision, breathing and movement, or noxious stimulation) to evoke an emotional response in the child such as rage or to cause the child to undergo a rebirth experience. Coercive techniques are sometimes also referred to as holding therapy, rage therapy, rage reduction therapy or rebirthing therapy.
5. Services wherein the therapist instructs and directs parents or others in the use of coercive techniques that are to be used with the child in the home or other setting outside the therapy session.

**2 - 3 Individual Psychotherapy (Individual Therapy)**

Individual therapy means face-to-face interventions with an individual client, with a focus on improving the client's emotional and mental adjustment and social functioning based on measurable treatment goals identified in the client's individual treatment plan.

**Record:**

For each session:

1. date and actual time of the service;
2. duration of the service;
3. setting in which the service was rendered;
4. specific service rendered;
5. treatment goal(s);
6. clinical note describing the client's progress toward treatment goal(s); and
7. signature and title of individual who rendered the service.

**Unit:**

**Individual Psychotherapy** - Insight oriented, behavior modifying and/or supportive, in an office or outpatient facility

**90804** - approximately 20 to 30 minutes face-to-face with the patient

**90806** - approximately 45 to 50 minutes face-to-face with the patient

**90808** - approximately 75 to 80 minutes face-to-face with the patient

**Individual Psychotherapy** - Interactive psychotherapy using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility

**90810** - approximately 20 to 30 minutes face-to-face with the patient

**90812** - approximately 45 to 50 minutes face-to-face with the patient

**90814** - approximately 75 to 80 minutes face-to-face with the patient

When billing or reporting any of the above psychotherapy treatment codes, round minutes to the nearest appropriate code. For example, if an individual therapy session lasts 37 minutes, use the applicable procedure code with a 20-30 minute time frame. If an individual therapy session lasts 38 minutes, use the applicable procedure code with a 45-50 minute time frame.

**Limits:** 1. Individual therapy is limited to individuals eligible for EPSDT (CHEC) services.

The following services are not covered services under Medicaid and may not be billed to Medicaid:

2. Services where the therapist or others during the session use coercive techniques (e.g., coercive physical restraints, including interference with body functions such as vision, breathing and movement, or noxious stimulation) to evoke an emotional response in the child such as rage or to cause the child to undergo a rebirth experience. Coercive techniques are sometimes also referred to as holding therapy, rage therapy, rage reduction therapy or rebirthing therapy.
3. Services wherein the therapist instructs and directs parents or others in the use of coercive techniques that are to be used with the child in the home or other setting outside the therapy session.

## 2 - 4 Family Psychotherapy

**Family psychotherapy** means face-to-face interventions with family members(e.g., parent or foster parent) on behalf of an identified client with a focus on improving the client's (and the family's) emotional and mental adjustment and social functioning based on measurable treatment goals identified in the client's individual treatment plan.

**Record:** For each session:

1. date and actual time of the service;
2. duration of the service;
3. setting in which the service was rendered;
4. specific service rendered;
5. treatment goal(s);
6. clinical note describing the client's progress toward treatment goal(s); and
7. signature and title of individual who rendered the service.



**Unit:**        **90847 - Family Psychotherapy - with patient present - per 15 minutes**

**90846 - Family Psychotherapy - without patient present - per 15 minutes\***

When billing or reporting these procedure codes, round to the nearest full unit. For example, 22 minutes of service equals 1 unit; 23 minutes of service equals 2 units.

**Limits:**     1. Individual therapy is limited to individuals eligible for EPSDT (CHEC) services.

The following services are not covered services under Medicaid and may not be billed to Medicaid:

2. Services where the therapist or others during the session use coercive techniques (e.g., coercive physical restraints, including interference with body functions such as vision, breathing and movement, or noxious stimulation) to evoke an emotional response in the child such as rage or to cause the child to undergo a rebirth experience. Coercive techniques are sometimes also referred to as holding therapy, rage therapy, rage reduction therapy or rebirthing therapy.
3. Services wherein the therapist instructs and directs parents or others in the use of coercive techniques that are to be used with the child in the home or other setting outside the therapy session.

## **2 - 5    Group Psychotherapy (Group Therapy)**

**Group psychotherapy** means face-to-face clinical treatment of two or more clients or families in the same session to improve the client's emotional and mental adjustment, and social functioning based on measurable treatment goals identified in the client's individual treatment plan. Groups should not exceed 10 individuals unless a co-therapist is present. Medicaid reimbursement may be claimed only for the Medicaid eligible clients in the group.

**Record:**     For each session:

1. date and actual time of the service;
2. duration of the service;
3. setting in which the service was rendered;
4. specific service rendered;
5. treatment goal(s);
6. monthly or per session clinical note describing the client's progress toward treatment goal(s); and
7. signature and title of individual who rendered the service.

If a clinical note summarizing progress toward treatment goals is written for each group session, then a monthly progress note is **not** also required.

**Unit:**        **90849 - Group Psychotherapy - Multiple-family group psychotherapy - per 15 minutes per client**

**90853 - Group Psychotherapy - Group psychotherapy (other than of a multiple-family group) - per 15 minutes per client**

**90857 - Group Psychotherapy - Interactive group psychotherapy using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication - per 15 minutes per client**

When billing or reporting these procedure codes, round to the nearest full unit. For example, 22 minutes of service equals 1 unit; 23 minutes of service equals 2 units.

**Limits:**

1. Group therapy is limited to individuals eligible for EPSDT (CHEC) services.

The following services are not covered services under Medicaid and may not be billed to Medicaid:

2. Services where the therapist or others during the session use coercive techniques (e.g., coercive physical restraints, including interference with body functions such as vision, breathing and movement, or noxious stimulation) to evoke an emotional response in the child such as rage or to cause the child to undergo a rebirth experience. Coercive techniques are sometimes also referred to as holding therapy, rage therapy, rage reduction therapy or rebirthing therapy.
3. Services wherein the therapist instructs and directs parents or others in the use of coercive techniques that are to be used with the child in the home or other setting outside the therapy session.

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### 3 PRIOR AUTHORIZATION

Prior authorization will **not** be required for services provided on or after October 1, 2003. For services provided before this date, prior authorization is still required. Prior authorization requests must include:

- A. Documentation of the course of the client's illness and treatment and a complete summary of client's current condition including symptomatology and behavior;
- B. The client's place of residence;
- C. The client's age;
- D. The setting in which the services will be rendered;
- E. Documentation of tentative DSM IV diagnoses on Axes I-V;
- F. Statement of prognosis if the prior authorization request is denied; and
- G. Statement outlining other alternatives considered or utilized.

Prior authorization must be obtained *in writing* from the Division of Health Care Financing, Bureau of Managed Health Care.

Send written requests to:

Bureau of Managed Health Care  
Division of Health Care Financing  
Box 143108  
Salt Lake City UT 84114-3108

or FAX to (801) 538-6099

Although verbal telephone authorization may be given when services must be given immediately, *a written request must be received and approved before any payment can be made.*

#### Telephone Prior Authorization

Verbal telephone authorization may ONLY be given when services must be given immediately. The psychologist must follow up with a written request in order to receive reimbursement for services.

In the Salt Lake City area, call 538-6501 or 538-6637.

To call toll-free from other areas, call Medicaid Information: ..... 1-800-662-9651

- You may call toll-free in Utah, Arizona, New Mexico, Nevada, Idaho, Wyoming and Colorado. (From all other states, call 1-801-538-6155)

- Ask for extension 86501 or extension 86637.

### **3 - 1 Specific Prior Authorization Criteria**

Prior authorization criteria are listed below.

#### **A. Prior authorization criteria for the initial evaluation**

Prior authorization for the initial evaluation may be granted if the psychologist documents the need for an evaluation to:

1. identify the existence, nature or extent of psychological impairment or deterioration of functioning; and
2. determine the need for medically necessary services.

#### **B. Prior authorization criteria for psychological testing**

Prior authorization for additional units of evaluation may be granted if the psychologist documents the need for continued assessment of a client due to the following:

1. Age or communicative ability of the client;
2. Difficulty developing a therapeutic relationship with the client;
3. Complexity of family involvement; or
4. Need for development of a complete in-depth psycho-social history.

#### **C. Prior authorization criteria for individual and group therapy**

Prior authorization may be granted if the psychologist documents the need to assess one or more of the following:

1. Neurological functioning;
2. Emotional functioning;
3. Behavioral functioning;
4. Intellectual functioning;
5. Accuracy of diagnosis when the results of previous testing are invalid or outdated; or
6. Nature of developmental disability.

#### **D. Prior authorization criteria for individual and group therapy**

Prior authorization may be granted if the psychologist documents the following:

1. DSM-IV diagnoses on Axis I-V;
2. Sufficient symptomatology to support the diagnoses and to warrant the requested treatment; and
3. Lack of other suitable treatment alternatives.

**4 REVISED PROCEDURE CODES FOR PSYCHOLOGY SERVICES rendered on or after October 1, 2003**

For each date of service, enter the appropriate five digit procedure code and modifier as indicated below:

Revised Codes	Service and Units	Limits per Patient
90801	<b>Psychiatric Diagnostic Interview Examination - per 15 minutes;</b>	No limit
90802	<b>Psychiatric Diagnostic Interview Examination</b> - Interactive psychiatric diagnostic interview examination using play equipment, physical devices, language interpreter, or other mechanisms of communication - <b>per 15 minutes</b>	No limit
96100	<b>Psychological Testing</b> - includes psychodiagnostic assessment of personality, psycho-pathology, emotionality, intellectual abilities, e.g., WAIS-R, Rorschach, MMPI, with interpretation and report - <b>per hour</b>	No limit
96105	<b>Assessment of Aphasia</b> - includes assessment of expressive and receptive speech and language function, language comprehension, speech production ability, reading spelling, writing, e.g., Boston Diagnostic Aphasia Examination, with interpretation and report - <b>per hour</b>	No Limit
96110	<b>Developmental Testing: limited</b> - e.g., Developmental Screening Test II, Early Language Milestone Screen, with interpretation and report - <b>per hour</b>	No Limit
96111	<b>Developmental Testing: extended</b> - includes assessment of motor, language, social, adaptive and/or cognitive functioning by standardized developmental instruments, e.g., Bayley Scales of Infant Development, with interpretation and report - <b>per hour</b>	No Limit
96115	<b>Neurobehavioral Status Exam</b> - Clinical assessment of thinking, reasoning and judgment, e.g., acquired knowledge, attention, memory, visual spatial abilities, language functions, planning, with interpretation and report - <b>per hour</b>	No limit
96117	<b>Neuropsychological Testing Battery</b> - e.g., Halstead-Reitan, Luria, WAIS-R, with interpretation and report - <b>per hour</b>	No Limit
	<b>Individual Psychotherapy</b> - Insight oriented, behavior modifying and/or supportive, in an office or outpatient facility	
90804	approximately 20 to 30 minutes face-to-face with the patient	No limit
90806	approximately 45 to 50 minutes face-to-face with the patient	No limit
90808	approximately 75 to 80 minutes face-to-face with the patient	No limit
	<b>Individual Psychotherapy</b> - Interactive psychotherapy using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility	
90810	approximately 20 to 30 minutes face-to-face with the patient	No Limit
90812	approximately 45 to 50 minutes face-to-face with the patient	No Limit
90814	approximately 75 to 80 minutes face-to-face with the patient	No Limit

<b>90847</b>	<b>Family Psychotherapy</b> - with patient present - <b>per 15 minutes</b>	No limit
<b>90846</b>	<b>Family Psychotherapy</b> - without patient present - <b>per 15 minutes</b>	No limit
<b>90849</b>	<b>Group Psychotherapy</b> - Multiple-family group psychotherapy - <b>per 15 minutes per client</b>	No limit
<b>90853</b>	<b>90853 - Group Psychotherapy</b> - Group psychotherapy (other than of a multiple-family group)	No limit
<b>90857</b>	<b>90857 - Group Psychotherapy</b> - Interactive group psychotherapy - <b>per 15 minutes per client</b>	No Limit

**5 OLD PROCEDURE CODES FOR PSYCHOLOGY SERVICES rendered before October 1, 2003**

**NOTE: Prior authorization is required for all services rendered before October 1, 2003.**

<b>PROCEDURE CODES FOR PSYCHOLOGY SERVICES</b>	
<b>Codes</b>	<b>Service and Units</b>
Y3200	Initial Evaluation, per 15 minutes
Y3205	Initial evaluation session for foster care children referred by DCFS, per 15 minutes
Y3206	Initial evaluation session for foster care children referred by DYC, per 15 minutes
Y3207	Initial evaluation session for children referred by DSPD, per 15 minutes
Y3220	Psychological testing, per 15 minutes
Y3225	Psychological testing for foster care children referred by DCFS, per 15 minutes
Y3211	Psychological testing for foster care children referred by DYC, per 15 minutes
Y3212	Psychological testing for children referred by DSPD, per 15 minutes
Y3230	Individual therapy, per 15 minutes
Y3235	Individual therapy for foster care children referred by DCFS, per 15 minutes
Y3213	Individual therapy for foster care children referred by DYC, per 15 minutes
Y3214	Individual therapy for children referred by DSPD, per 15 minutes
Y3240	Group therapy per hour, per 15 minutes
Y3245	Group therapy for foster care children referred by DCFS, per 15 minutes
Y3216	Group therapy for foster care children referred by DYC, per 15 minutes
Y3217	Group therapy for children referred by DSPD, per 15 minutes

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